

A plan can look affordable on paper and still be a poor fit if employees can't use the hospital they rely on. The same hospital may be in-network for one insurance product and out-of-network for another—even when both plans carry the same insurer's name. Provider networks can also differ by county, plan type, and coverage year.

Before comparing premiums, ask: **Who is in-network for our employees' ZIP codes?** Then verify the specific hospital, clinics, and doctors against the exact plan you're considering. This guide explains how to do that, where small businesses can shop, and what to check before settling on a group plan or a health reimbursement arrangement (HRA).

Start with the Exact Hospital and the Exact Plan

"The hospital takes this insurance" is not a reliable enough answer. A hospital may participate in an insurer's broad network but not in a particular narrow-network plan. It may also have multiple campuses, outpatient centers, or affiliated physician groups with different network status.

For each location your employees care about, check:

- **The facility:** Confirm the hospital's exact name, campus, and address.
- **Clinics and outpatient services:** A hospital's imaging center, urgent care, lab, or surgery center may be billed separately.
- **Doctors and other clinicians:** Check primary care doctors, specialists, anesthesiologists, and other professionals employees may use.
- **The plan's network name:** Don't stop at the carrier's brand name. Record the network and product name shown in the plan materials.
- **The coverage year:** A network can change at renewal, even if the plan name looks familiar.

For a dependable **provider network check**, use the insurer's directory for the exact plan and call the carrier to confirm. Then call the hospital's billing or insurance office and ask whether it is in-network for that exact plan. Keep the date, phone number, representative's name or ID, and the answer in writing if possible.

How to Verify In-Network Hospitals

1. **Make a list of locations first.** Ask employees which hospitals, doctors, and clinics matter to them. Collect ZIP codes for home and work locations, especially if your team works remotely or across state lines.
2. **Get the plan's full identity.** Ask for the carrier, plan name, network name, metal tier if applicable, and plan year. A logo or marketing summary is not enough.
3. **Search the carrier directory.** Search by facility name and address. Save a copy or screenshot of the result, including the search date.
4. **Call the carrier using the number for members or prospective members.** Ask directly: "Is this facility in-network for this exact plan and ZIP code?" Also ask about affiliated outpatient facilities and physician groups.
5. **Confirm with the hospital.** Provide the exact plan and network name. Ask whether the hospital is contracted as in-network, not merely whether it "accepts" the carrier.
6. **Repeat for key clinicians.** A hospital stay can involve separate bills from doctors who do not share the hospital's network status.
7. **Save your evidence.** Keep directory results, call notes, and any written confirmations with your renewal comparison.

Directories are useful starting points, not a guarantee of future coverage. Provider contracts can change, and a directory can be out of date. If a carrier representative gives a clear answer, ask for a reference number or written confirmation. Review the plan's documents for rules on referrals, prior authorization, emergency care, and out-of-network services, too.

Where Small Businesses Can Shop

Small employers often compare options beyond the public health insurance marketplace exchange because they want different contribution arrangements, plan designs, or access to a broker who can help with enrollment and renewal. Depending on the state and the business's circumstances, options may include individual coverage through the exchange, small-group coverage through an exchange or insurer, direct-to-carrier group plans, or an HRA arrangement that reimburses employees for eligible individual coverage.



Availability and rules vary by state and year. The public marketplace exchange is still an important place to understand individual coverage and any available financial assistance. For eligible people, subsidies may affect the cost of individual marketplace plans. An employer-funded HRA can affect an employee's eligibility for that assistance, so employees should check their own circumstances before enrolling. Don't assume an employer contribution and marketplace assistance can simply be stacked together.

Broker vs. Direct-to-Carrier Shopping

Working with a broker

A broker can gather quotes, explain plan designs, help with enrollment, and flag small-group requirements. A broker who knows your local market may also help you compare networks across carriers. Ask how the broker is compensated, which carriers they represent, whether they can show plans from the full market available to your business, and who will help after enrollment.

Still, don't treat a broker's summary as the final network check. Ask for the exact plan documents and network details. Then verify the hospitals and clinicians yourself with the carrier and provider. The broker can help coordinate the questions, but you want the answers tied to the specific plan.

Shopping directly with a carrier

Going direct can be useful if you already know which insurer or network you want to investigate. You can request small-group quotes, plan documents, eligibility criteria, and directory information from the carrier. The trade-off is that you may need to contact several [tradersdna](#) carriers and do more of the comparison work yourself.

Whichever route you use, put every option on a one-page comparison sheet. Include network, local hospital status, employee costs, employer contribution, deductible, out-of-pocket maximum, prescription coverage, eligibility rules, and renewal date. This keeps a low premium from distracting everyone from an important coverage gap.

Small-Group Eligibility and Participation Rules

Before you compare small-group plans, confirm that the business and the people you want to cover qualify. Rules vary by state and insurer, but carriers commonly review factors such as the number of eligible employees, business documentation, employee work status, and whether the business has a valid employer–employee relationship. Owners, partners, family members, and seasonal or part-time workers may be treated differently under applicable rules.

Participation requirements may also apply. A carrier could require a certain share of eligible employees to enroll, subject to rules about employees who have other qualifying coverage. Employer contribution minimums may apply as well. The details can depend on state law, the carrier, the size of the group, and the time of year.

Ask these questions before spending time comparing plan prices:

- What counts as an eligible employee for this quote?
- How many employees must enroll, and how is the participation rate calculated?
- How much must the employer contribute toward premiums?
- How are employees with other coverage treated in the participation calculation?
- Are remote employees living in another state eligible, and which networks are available where they live?
- What documents are needed to establish the business and the group?

Get the answers from the carrier or a qualified broker in writing. A group that looks eligible at first glance may not meet the insurer’s enrollment or contribution rules. Remote employees deserve special attention: a plan that works for staff near your office may have a thin or unusable network in another ZIP code.

What If a Traditional Group Plan Isn’t a Fit?

Some small businesses consider an HRA-style arrangement instead of choosing one group plan for everyone. An HRA is an employer-funded arrangement that reimburses eligible medical expenses, subject to the rules for that particular HRA. It is not the same as giving employees unrestricted cash for health costs.

Common HRA approaches

- **Qualified Small Employer HRA (QSEHRA):** Generally designed for eligible small employers that do not offer a group health plan. It has annual reimbursement limits and other rules. Employees may use reimbursements for eligible expenses, including qualifying individual insurance premiums.
- **Individual Coverage HRA (ICHRA):** Employers can offer an allowance for eligible individual coverage, subject to requirements such as substantiation and rules about employee classes. The employer generally cannot offer the same class both an ICHRA and a traditional group plan.

- **Other limited-purpose arrangements:** Some arrangements reimburse only certain expenses and may not replace comprehensive health insurance.

With an HRA, employees generally choose their own individual plans, so there may not be one shared network for the whole team. That can help employees select coverage suited to their own ZIP code and doctors, but it also means each person needs to check their own **in-network hospitals** and providers. The employer should set a clear, consistent allowance and use appropriate administration. HRA rules can be technical; work with a benefits professional or tax adviser before setting one up.

How to Compare Health Insurance Networks Fairly

When you **compare health insurance networks**, compare actual provider access—not just network labels. Build a short list of must-have hospitals, doctors, and service locations, then evaluate each candidate plan against it. If employees live in different areas, create a separate check for each ZIP code or region.

What to compare	What to record	Why it matters
Hospital and campus confirmation date	Exact facility name, address, and plan network	A health system's locations may not all participate in the same network.
Doctors and services	Primary care, specialists, labs, imaging, and outpatient centers	Care may be billed by separate organizations with different network status.
Coverage costs	Premium, deductible, copays, coinsurance, and out-of-pocket maximum	A lower premium can come with higher costs when employees need care.
Plan rules	Referrals, prior authorization, prescription formulary, and out-of-network rules	These affect access and total cost, even when a preferred hospital is in-network.
Employer requirements	Eligibility, participation, contribution, and enrollment deadlines	A plan is not a practical option if the group cannot satisfy its requirements.

For an individual marketplace plan, use the public exchange's tools to review plan availability and estimated costs, then check the insurer's provider directory for the specific plan. The exchange helps people compare coverage, but the carrier's plan-specific network information is essential for verifying a hospital. If employees need marketplace coverage, encourage them to review the official marketplace for their state and carefully check how any employer benefit affects financial assistance.

Use Google Preferred Sources for Ongoing Research

Google's Preferred Sources feature can help you see more updates from selected publications and organizations in eligible Google Search experiences. If you use the feature, follow or add sources that publish reliable health coverage information—such as your state's official insurance department, the public marketplace, or established consumer health policy organizations. Look for the "follow" or "add to preferred sources" prompt when it appears in Google Search.



This is a way to keep up with general news and explainers, not a provider directory or a substitute for checking a specific plan. A preferred source cannot confirm that your local hospital is in-network. For that, use the plan's current carrier directory and confirm directly with the carrier and the hospital.

A Practical Renewal Checklist

1. Collect employees' home ZIP codes and the hospitals, doctors, and clinics they want to keep.
2. Confirm small-group eligibility, participation, and employer contribution rules.
3. Request the full plan name, network name, summary of benefits, and provider directory for each option.
4. Verify hospitals and key clinicians for each employee location—not only the business address.
5. Compare costs and plan rules alongside network access.
6. Save directory results and call notes, and confirm again before enrollment if the network or plan changes.
7. Review marketplace and HRA options with an appropriate benefits professional if a group plan doesn't fit.

The safest choice is not automatically the cheapest plan or the carrier employees recognize. It is the plan—or reimbursement approach—that meets the business's eligibility requirements, fits the team's locations and budget, and gives employees workable access to the hospitals and clinicians they rely on. Make the network check a first step, document what you find, and revisit it at every renewal.